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Notice of Independent Review Decision

DATE: June 18, 2013

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

IP Lumbar Decompression L3-L5, Mini 360 L5-S1 with 2 Day LOS

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is certified by the American Board of Orthopaedic Surgeons with 42 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

10/13/11: Physician Documentation
10/13/11, 10/27/11: Treatment Memo
10/20/11: Treatment Memo
10/25/11: MRI L Spine without Contrast report interpreted
12/13/11: Treatment Memo
01/20/12: Evaluation
02/21/12: Treatment Memo
02/29/12: Evaluation Summary
03/15/12, 03/29/12, 05/03/12: Treatment Memo
04/09/12: Progress Note
04/09/12: Discharge Note
05/03/12: Treatment Memo
06/06/12: Initial Evaluation
06/06/12: Functional Capacity Evaluation
06/25/12: Initial Neurosurgical Consultation
06/26/12: Treatment Memo
07/30/12: Discharge Summary

12/17/12: Report of Medical Evaluation
01/21/13: Office Visit from Occupational Medicine (No physician listed)
02/04/13: Office Visit
02/08/13: Notification of Workers' Compensation Referral
02/25/13: CA Notes
02/28/13: Followup Visit
02/28/13: Radiology Report
03/07/13: Treatment Memo
03/18/13: Psychological Evaluation
04/02/13: UR performed
04/23/13: UR performed

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who injured his low back when he was stepping of a truck and twisted his lower back and caught himself on the door window on xx/xx/xx. He is status post physical therapy, chiropractic treatment, and epidural steroid injections.

10/25/11: MRI L Spine without Contrast report interpreted by. IMPRESSION: L5-S1: 5 mm posterior disc bulge, superimposed 6 mm left paracentral disc protrusion, disc contour abnormalities, osteophytes, and facet hypertrophy cause moderate spinal canal stenosis and severe stenosis of the left lateral recess as well as neural foraminal stenosis. L3-L4: 5 mm left foraminal disc protrusion with annular fissure. L4-L5: 3 mm disc bulge. Mild spinal canal stenosis with accompanying left neural foraminal stenosis at L3-L4 and L4-L5. 3 mm retrolisthesis of L4 on L5 and L3 on L4.

06/25/12: The claimant was evaluated. He complained of intermittent low back pain radiating down the anterior aspect of the left lower extremity associated with burning, numbness, and tingling. His left leg would go out causing him to fall, he had fallen a total of six times. It was noted that he had received two pain blocks in the lower back which were moderately effective. On exam, he had limited lumbar range of motion. Straight leg raising was positive at 50 degrees on the left and negative on the right. Femoral stretch was ++ on the left and negative on the right. There was weakness of the left hip flexors, ipsilateral quadriceps, ventroflexors and dorsiflexors of the foot. He was not able to ambulate on his tip toes and heels. He was not able to overcome moderate resistance. Weakness estimated 50 percent as compared to the opposite side. There was obvious atrophy of the left thigh and of the left leg about 2". There was an absent left patellar reflex and a depressed left Achilles reflex. There was hypalgesia in the distribution of the left L3-L4, L4-L5, and L5-S1 dermatomes. IMPRESSION: Manifestations of lumbar and lumbosacral radiculopathy. MRI shows significant extradural defects with spondylolisthesis at L3-L4, L4-L5 and a large extradural defect at L5-S1. Recommend minimally invasive TLIF at L3-L4 and L4-L5 and a minimally invasive left L5-S1 laminectomy and microdiscectomy.

02/04/13: The claimant was evaluated. He continued to have pain in the back and hips and "nerve pain" in the left leg. It was noted that his knees would "fold

under” when he walked on uneven ground or incline or for long distances. He asked for stronger pain meds as the OTC analgesics were not helping with his pain at night. Tramadol was noted to not help. On exam, he winced with lifting his low back and left leg. Left thigh compression caused more discomfort than range of motion testing. Strength testing remained fair with passive motion against resistance to pushing down while he pushed p with his hips flexed bilaterally. He had loss of tone in the left thigh. Weak quads in the left. Laxity in the knees. SLR ipsilateral finding at 40 degrees on the left. Asymmetric DTRs right patella 4/5 left 2/5. Atrophy in the thigh and calf of more than 2 cm in the left thigh compared to right. He had bowing out of the left knee. PLAN: Chiropractic referral. Second opinion for surgery. Consider work hardening after surgical opinion if not considered surgical candidate.

02/28/13: The claimant was evaluated for low back pain, leg pain, motor weakness, and sensory loss. On exam, he had an abnormal gait pattern with the left lower extremity. He showed some signs of buckling of his left knee. He was unable to stand on his toes any length of time due to weakness as well as his heels. In the left lower extremity, he had 3+/5 strength testing with knee extension. He had 3+/5 strength testing with plantar flexion and 4/5 strength testing with dorsiflexion. He had decreased sensation in L3, L4, and L5 dermatomes. He had a positive SLR on the left side and negative on the right. He had good range of motion in the lower extremities. He had some pain and tenderness about the region of L3, L4, and L5 diffuse in the paraspinal musculature. He had to bend forward in a hunched over position in order to walk. MRI showed substantial compression and stenosis primarily at the L5-S1 segment, also noted at L3-L4, which contributed to thigh atrophy, weakness, and DTR change. recommended surgery with decompressive laminectomy and discectomy at L3-L4 to take remove the L3-L4 disc protrusion and decompress this level of nerve root. At L5-S1, surgical fusion because of instability that was going to be created with the significant amount of decompression and facetectomy that was going to be required particularly on the left side as well as removal of the herniated nucleus pulposus on the left side. noted that there was also significant foraminal stenosis which at the time of the fusion surgery would also be addressed with indirect foraminal decompressions.

02/28/13: Radiology Report. X-rays show significant disc space narrowing seen at L5-S1 segment. There is no instability seen at L4-L5 or L3-L4. MRI scan shows extruded disc herniation at L5-S1 causing severe spinal stenosis and lateral recess stenosis on the left side. There is also large facet joint hypertrophy, also contributing to the stenosis on the left side. There ipsilateral neural foraminal stenosis and significant disc space narrowing at L5-S1. At L4-L5, mild disc desiccation is noted and some mild stenosis seen. At L3-L4, on the left side, there is disc protrusion seen on the left side at L3-L4, based off the fact that also on exam he is noted to have significant calf atrophy on the left side compared to the right side as well as thigh atrophy on the left side versus the right side.

03/18/13: The claimant was evaluated who noted that surgery was not contraindicated by his psychological evaluation. He was noted to have a good

prognosis for a successful outcome to his proposed surgery. Postsurgical counseling was noted to be beneficial to optimize compliance of postop treatment plan.

04/02/13: UR performed. REVIEWER COMMENTS: The MRI of the lumbar spine dated 10/25/11 revealed at the L3-L4 level a broad-based 5 mm left foraminal disc protrusion with an annular fissure. There was moderate-severe stenosis of the left neural foramen and left lateral recess. Mild spinal canal stenosis was also present with the thecal sac measuring 8 mm AP. Facet degenerative changes were noted as well. At the L4-L5 level, a 3 mm disc bulge and degenerative facet and ligamentous hypertrophy were present. There was mild spinal canal stenosis and mild left neural foraminal stenosis. The thecal sac measured 8.5 mm AP. At the L5-S1 level, a 5 mm posterior disc bulge was present and there was a superimposed 6 mm left paracentral disc protrusion. There was moderate spinal canal stenosis, severe stenosis of the left lateral recess, and a mild bilateral neural foraminal stenosis was also present at this level. The clinical note evidenced that the patient received a psychological clearance prior to the requested surgical intervention. The clinical notes document upon physical exam of the patient, objective findings included positive straight leg raising to the left, deep tendon reflexes to the right patella 4/5 and on the left 2/5, and the ankle was mildly hyperreflexic to the left. The provider documented atrophy in the thigh and calf of more than 2 cm in the left thigh compared to the right. The clinical notes evidence the patient utilized rest, physical therapy, exercise, unspecified injections, TENS unit, massage therapy, and a variety of medications prior to the requested surgical interventions. The clinical note submitted for review documents the patient presents with moderate complaints of pain to the lumbar spine. After review of the imaging study of the patient's lumbar spine, surgical interventions would be supported at the L3-L4 and L5-S1 levels. However, at the L4-L5, significant pathology was not evidenced to support surgical interventions at this point in the patient's treatment. The provider is requesting an L3-L5 decompression with mini 360 fusion at L5-S1. A fusion at the L5-S1 level would be indicated as the patient presents with bilateral discs at this level which would require a wide decompression which in turn would have the patient present with iatrogenic instability postoperatively. However, given all of the above, the request for IP L3-L5 decompression, mini 360 at L5-S1 with 2 day LOS is non-certified.

04/23/13: UR performed. REVIEWER COMMENTS: His findings would support a decompression at L3-L4 and L4-L5 as recommended. The request also includes a mini 360 degree fusion at L5-S1. The MRI indicates that at L5-S1, there is a 5 mm posterior disc bulge superimposed upon a 6 mm left paracentral disc protrusion and he has moderate spinal canal stenosis and severe stenosis of the left lateral recess, and there is mild bilateral neural foraminal stenosis with endplate osteophytes and degenerative facet hypertrophy. There is also a 3 mm retrolisthesis of L3 on L4 and L4 on L5. It is indicated that he would need the fusion at L5-S1 due to the instability that is going to be created with the significant amount of decompression and facetectomy that is going to be required, particularly in the left, as well as removal of the herniated disc on the left side.

There was also significant foraminal stenosis which at the time of the fusion surgery will be addressed with an indirect foraminal decompression. However, the request includes decompression at L3-L5 and this would not touch the L5-S1 level. Therefore, the rationale for fusion, creating iatrogenic instability at L5-S1, is a moot point. The clinical notes do not correspond with the request. Therefore, this request is not considered medically necessary and is non-certified.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decisions are upheld. After review of available medical records, it appears that the patient has a herniated disc with nerve root impingement at L3-L4 on the left and at L5-S1 on the left. These findings would warrant a left L3-L4 laminectomy and discectomy and left L5-S1 laminectomy and discectomy. However, there are no ODG indications for an L5-S1 fusion. Decompression at L3-L5 would not address the L5-S1 level. Therefore, the request for IP Lumbar Decompression L3-L5, Mini 360 L5-S1 with 2 Day LOS is not medically necessary and is not certified.

ODG:

<p>Discectomy/ laminectomy</p>	<p>ODG Indications for Surgery™ -- Discectomy/laminectomy -- Required symptoms/findings; imaging studies; & conservative treatments below: I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following: A. L3 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps weakness 3. Unilateral hip/thigh/knee pain B. L4 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness 3. Unilateral hip/thigh/knee/medial pain C. L5 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain D. S1 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness 3. Unilateral buttock/posterior thigh/calf pain (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.) II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis Diagnostic imaging modalities, requiring ONE of the following: 1. MR imaging 2. CT scanning 3. Myelography 4. CT myelography & X-Ray</p>
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	<p>III. <u>Conservative Treatments</u>, requiring ALL of the following:</p> <p>A. <u>Activity modification</u> (not bed rest) after <u>patient education</u> (>= 2 months)</p> <p>B. Drug therapy, requiring at least ONE of the following:</p> <ol style="list-style-type: none"> 1. <u>NSAID</u> drug therapy 2. Other analgesic therapy 3. <u>Muscle relaxants</u> 4. <u>Epidural Steroid Injection</u> (ESI) <p>C. Support provider referral, requiring at least ONE of the following (in order of priority):</p> <ol style="list-style-type: none"> 1. <u>Physical therapy</u> (teach home exercise/stretching) 2. <u>Manual therapy</u> (chiropractor or massage therapist) 3. <u>Psychological screening</u> that could affect surgical outcome 4. <u>Back school</u> (<u>Fisher, 2004</u>) <p>For average hospital LOS after criteria are met, see <u>Hospital length of stay</u> (LOS).</p>
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Fusion (spinal)	<p>Patient Selection Criteria for Lumbar Spinal Fusion:</p> <p>For chronic low back problems, fusion should not be considered within the first 6 months of symptoms, except for fracture, dislocation or progressive neurologic loss. Indications for spinal fusion may include: (1) Neural Arch Defect - Spondylolytic spondylolisthesis, congenital neural arch hypoplasia. (2) Segmental Instability (objectively demonstrable) - Excessive motion, as in degenerative spondylolisthesis, surgically induced segmental instability and mechanical intervertebral collapse of the motion segment and advanced degenerative changes after surgical discectomy, with relative angular motion greater than 20 degrees. (<u>Andersson, 2000</u>) (<u>Luers, 2007</u>) (3) Primary Mechanical Back Pain (i.e., pain aggravated by physical activity)/Functional Spinal Unit Failure/Instability, including one or two level segmental failure with progressive degenerative changes, loss of height, disc loading capability. In cases of workers' compensation, patient outcomes related to fusion may have other confounding variables that may affect overall success of the procedure, which should be considered. There is a lack of support for fusion for mechanical low back pain for subjects with failure to participate effectively in active rehab pre-op, total disability over 6 months, active psych diagnosis, and narcotic dependence. Spinal instability criteria includes lumbar inter-segmental movement of more than 4.5 mm. (<u>Andersson, 2000</u>) (4) Revision Surgery for failed previous operation(s) if significant functional gains are anticipated. Revision surgery for purposes of pain relief must be approached with extreme caution due to the less than 50% success rate reported in medical literature. (5) Infection, Tumor, or Deformity of the lumbosacral spine that cause intractable pain, neurological deficit and/or functional disability. (6) After failure of two discectomies on the same disc, fusion may be an option at the time of the third discectomy, which should also meet the ODG criteria. (See <u>ODG Indications for Surgery -- Discectomy.</u>)</p> <p>Pre-Operative Surgical Indications Recommended: Pre-operative clinical surgical indications for spinal fusion should include all of the following: (1) All pain generators are identified and treated; & (2) All physical medicine and manual therapy interventions are completed; & (3) X-rays demonstrating spinal instability and/or myelogram, CT-myelogram, or discography (see <u>discography criteria</u>) & MRI demonstrating disc pathology correlated with symptoms and exam findings; & (4) Spine pathology limited to two levels; & (5) <u>Psychosocial screen</u> with confounding issues addressed. (6) For any potential fusion surgery, it is recommended that the injured worker refrain from smoking for at least six weeks prior to surgery and during the period of fusion healing. (<u>Colorado, 2001</u>) (<u>BlueCross BlueShield, 2002</u>)</p> <p>For average hospital LOS after criteria are met, see <u>Hospital length of stay</u> (LOS).</p>
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Hospital length of stay (LOS)	<p>ODG hospital length of stay (LOS) guidelines:</p> <p>Discectomy (<i>icd 80.51 - Excision of intervertebral disc</i>)</p> <p>Actual data -- median 1 day; mean 2.1 days (± 0.0); discharges 109,057; charges</p>
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	<p>(mean) \$26,219 Best practice target (no complications) -- <i>Outpatient</i> Laminectomy (<i>icd 03.09 - Laminectomy/laminotomy for decompression of spinal nerve root</i>) Actual data -- median 2 days; mean 3.5 days (± 0.1); discharges 100,600; charges (mean) \$34,978 Best practice target (no complications) -- <i>1 day</i> <i>Note: About 6% of discharges paid by workers' compensation.</i> Lumbar Fusion, posterior (<i>icd 81.08 - Lumbar and lumbosacral fusion, posterior technique</i>) Actual data -- median 3 days; mean 3.9 days (± 0.1); discharges 161,761; charges (mean) \$86,900 Best practice target (no complications) -- <i>3 days</i> <i>Note: About 15% of discharges paid by workers' compensation.</i> Lumbar Fusion, anterior (<i>icd 81.06 - Lumbar and lumbosacral fusion, anterior technique</i>) Actual data -- median 3 days; mean 4.2 days (± 0.2); discharges 33,521; charges (mean) \$110,156 Best practice target (no complications) -- <i>3 days</i> Lumbar Fusion, lateral (<i>icd 81.07 - Lumbar fusion, lateral transverse process technique</i>) Actual data -- median 3 days; mean 3.8 days (± 0.2); discharges 15,125; charges (mean) \$89,088 Best practice target (no complications) -- <i>3 days</i></p>
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- INTERQUAL CRITERIA**
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- MILLIMAN CARE GUIDELINES**
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TEXAS TACADA GUIDELINES**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**